STATE OF MICHIGAN

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 85830-001**

v

Physicians Health Plan of Mid-Michigan
Respondent

Issued and entered
this 8th day of November 2007
by Ken Ross
Acting Commissioner

ORDER

I
BACKGROUND

On October 19, 2007, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for expedited external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

A request for an expedited external review under PRIRA will be accepted if the conditions in Section 13(1)[1] are met

> (1) Except as provided in subsection (11), a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner within 10 days after the covered person receives an adverse determination if both of the following are met:
> (a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function as substantiated by a physician either orally or in writing.

[1] MCL 550.1913(1).

> (b) The covered person or the covered person's authorized representative has filed a request for an expedited internal grievance.

In this case, there has been no physician substantiation that the Petitioner's life or health or his ability to regain maximum function would be jeopardized. However, after a preliminary review of the material submitted, the Commissioner accepted the request for external review as a non-expedited case.

The issue in this matter can be resolved by analyzing the Physician's Health Plan of Mid-Michigan (PHP) certificate of coverage (the certificate), the contract defining the Petitioner's health benefits. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner, born XXXXX, is a member of Physicians Health Plan of Mid-Michigan (PHP). Except in very limited situations, he does not have coverage for non-network benefits. He also has secondary health care coverage from Blue Cross and Blue Shield as an eligible dependent of his wife.

On September 14, 2007, the Petitioner had a colonoscopy and colonscopic polypectomy. An adenomatous polyp was found and removed. The Petitioner says that XXXXX, MD, who performed the procedures, recommended and referred him to the XXXXX for consultation and treatment due to the serious nature of his condition.

On September 27, 2007, through his primary care physician, the Petitioner requested coverage for consultation and treatment at XXXXX. XXXXX is not part of the PHP network of contracted providers. On September 28, 2007, PHP denied the request, advising the Petitioner

that care from a non-network provider was denied because it is available from network physicians at the XXXXX.

The Petitioner had consultations at XXXXX on October 3, 4, 5, and 8, 2007, and said in his request for external review that he was scheduled for surgery at XXXXX on October 24, 2007. He requested coverage from PHP for these services. The Petitioner appealed through PHP's expedited internal grievance process but PHP maintained its denial and sent a final adverse determination letter dated October 2, 2007.

III
ISSUE

Was PHP's denial of coverage for services from an out-of-network provider correct?

IV
ANALYSIS

Petitioner's Argument

On September 14, 2007, the Petitioner was admitted to the hospital for a colonoscopy for evaluation of hemoccult positive stool. He had no prior history of rectal bleeding, polyps, or inflammatory bowel disease. Dr. XXXXX's "report of operation" detailed the following:

> After adequate sedation, digital examination showed normal sphincter tones. No masses were noted in the rectum. The colonoscope was inserted into his rectum and immediately encountered a large sessile polyp at about 8cm. This was large in size measuring almost 8cm in length. We went beyond this and could finish the colonoscopy. The cecum and ascending colon were essentially unremarkable. Likewise, the transverse colon showed no evidence of inflammation or neoplasm. Descending colon showed no evidence of inflammation or neoplasm. In the sigmoid colon at 50cm, we encountered a small polypoid mass measuring about a centimeter in size. This was snared and excised, retrieved and submitted to Pathology.
>
> We then went to work on the large rectal polyp. This had such a large base that we were unable to get the snare around it completely and thus had to take it out in a piecemeal fashion. Large sections of the mass were excised. This was very soft and mushy compatible with a villous adenoma. Bits and pieces were

> taken out and we actually accomplished a fair resection. When this was completed, we could see the muscular wall fairly clearly. Because of the large size of the polyp, it was difficult to determine if the resection was complete. We will be having him come back in approximately 6-8 weeks to repeat the scoping to see if there is any evidence of residual. Subsequently, the tissue was submitted to the Lab looking for any evidence of atypia or malignancy.

After the colonoscopy, the surgical pathology report noted, "Due to fragmentation of the specimen, invasive carcinoma cannot be ruled out."

The Petitioner says he should be treated at XXXXX because it is one of two places Dr. XXXXX, a specialist, recommended and he was following that recommendation. The Petitioner also argues that because he followed PHP's direction and obtained a referral from his PCP, he assumed it would be honored.

It is the Petitioner's position that treatment at the XXXXX was and is medically necessary and there were no appropriate alternative sources of care within PHP's network of contracted providers.

Physicians Health Plan of Mid-Michigan

In its final adverse determination, PHP denied the request for in-network coverage for services from a non-network provider because the services are available with PHP's network of providers such as XXXXX. PHP bases its argument on the following provisions in the certificate:

> **Section 1: What's Covered – Benefits**
>
> ***Accessing Benefits***
> To obtain Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility.
>
> You must select a Primary Physician to provide or coordinate Covered Health Services you receive.
>
> * * *
>
> The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness or Mental Illness, or the fact that the Physician has determined that a particular health care service or supply is Medically Necessary or medically appropriate, does not

> mean that the procedure or treatment is a covered health Service under the Policy.
>
> * * *
>
> ***Your Notification Responsibility – Non-Network Providers***
> If you have been referred to a non-Network provider, it is your responsibility to contact us to determine if Benefits will be available for services received from that non-Network provider. We pay for Covered Health Services from non-Network providers only if we determine that we do not have a provider in the Network that can perform a necessary Covered Health Service. If you don't notify us, and we later determine that your referral to a non-network provider does not meet our criteria, Benefits will not be paid and you will be responsible for all costs associated with those services.
>
> * * *
>
> ***Benefits for Health Services from Non-Network Providers***
> If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for benefits when Covered Health Services are received from non-network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-network provider without verifying in advance that we have approved your visit, we will not pay Benefits and you will be held financially responsible for the entire cost of the services you receive.

PHP says that under the certificate there are no benefits for services from an out-of-network provider when care is available from network providers or if the services are not authorized by PHP. PHP says it told the Petitioner that care for rectal cancer was available from network providers such as XXXXX.

PHP says its denial is consistent with its certificate, which requires members to use network providers when available.

Commissioner's Review

The Commissioner must decide if PHP properly denied care from a non-network provider under the terms of the certificate.

PHP gives two reasons for denying coverage: (1) there is no out-of-network coverage for health services when care is available from within its network of contracted providers, and (2)

care was available within its network.

A fundamental premise of a health maintenance organization (HMO) is the centralization of health care delivery within a network of providers who sign contracts and agree to accept negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. If an HMO member uses an out-of-network provider, payment may be greatly reduced or even excluded entirely by the HMO. Under state law, an HMO may deny coverage for services from non-network providers when the care is available in-network unless it is authorized in advance.

While it is understandable that the Petitioner would want to receive care from a facility recommended by his physician, the certificate requires that he receive services from network providers unless the out-of-network care is authorized by PHP. No such authorization was made in this case.

In addition, there is no evidence in the record from which the Commissioner could conclude that services could not be provided within PHP's network. The Petitioner was seen by his primary care physician and one local specialist, but he was not seen by any oncologist or specialist at one of PHP's contracted tertiary centers such as the XXXXX or the XXXXX. PHP identified several providers: it says the Petitioner could have been seen at XXXXX immediately after his colonoscopy (when he declined, the next available date was December 2007) or he could have been treated in XXXXX on October 22, 2007, or at XXXXX on October 29, 2007.

After Dr. XXXXX recommended XXXXX, the Petitioner's primary care physician requested a referral there from PHP. PHP denied the request initially on September 28, 2007, and again on October 2, 2007, after conducting an expedited internal grievance while the Petitioner was enroute to XXXXX. PHP denied coverage because it was not established that the services the Petitioner needed were not available elsewhere in its network.

The Petitioner was obligated by the terms of his coverage to receive services from within

the network absent a showing that the needed care was only available outside the network. The Commissioner acknowledges that out-of-network care might be justified if it is shown that an HMO does not "maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay." See MCL 500.3530. However, the Commissioner cannot find on this record that PHP did not have sufficient providers to treat the Petitioner.

The Commissioner finds that PHP has properly applied the provisions of its certificate in this case.

V
ORDER

The Commissioner upholds PHP's October 2, 2007 final adverse determination. PHP is not required to cover the Petitioner's consultation and treatment from an out-of-network provider under the terms of the certificate and the facts in this case.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.